# Children's Mental Health Waiver
## Discharge Plan

Name of Youth: _____

Current Service Plan Date: _____ Date of Discharge Plan Meeting: _____

**Reason for Discharge:**

☐ Service plan goals are met

☐ Maximum age reached

☐ Relocation of child/family outside state of Wyoming

☐ Youth/Family choice to terminate waiver services

☐ Out of home care stay > 120 days

☐ Change in medical condition

☐ Lack of safe living arrangements

☐ Waiver appropriate level of care requirements no longer met

☐ Medicaid eligibility criteria no longer met

☐ Youth/family refusal of critical plan services

☐ Lack of cooperation in service plan development and implementation (all options attempted)

☐ Wyoming State Hospital admission > 120 days

☐ Incarceration (Custody of a state, local or federal law enforcement agency)

☐ Cost of services

☐ Death of child

☐ Other (specify): _____

**Identify Community Supports Established**

Mental Health Professional _____

Date for Next Visit: _____

Medical Care Professional _____

Date for Next Visit: _____

Family Support Advocate _____

Date for Next Visit: _____

School Representative _____

Other (specify) _____
Other (specify) _____

Other (specify) _____

Other (specify) _____

**Waiver Discharge Date:** _____

**Team's Prognosis for Successful Youth/Family Discharge**

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Rationale:

**Additional Information:**

Team Members present:

_____ _____

_____ _____

_____ _____

_____ _____

Family Care Coordinator: _____ Date: _____

Reviewed by MHSASD_____ Date: _____